

WAIVER WEB-SITE INQUIRIES

From May 29 to June 19, 2002

► We need to establish a Washington State-run DSHS pharmacy for the purpose of recycling Medicaid-funded medications that are systematically destroyed daily at nursing facilities all over the state. These are expensive narcotics, which are destroyed because the patients die, are discharged, or physician discontinues the orders for the medications. We nurses routinely flush these drugs down the sewer while people suffer in pain for want of these drugs but have no coverage. My employer uses a pharmacy at a distance, and every day our medications are shipped in and out via courier. We could work with a State pharmacy in the same manner, or the state could contract an existing pharmacy to do the task. I also wonder about all the other RX which we return to the pharmacy for account credit after the above scenarios: are we monitoring that MEDICAID is being reimbursed for the cost outlay of these drugs, or is this money unaccounted for? No doubt it totals in the millions annually.

We also need to look at refill quantities. Pharmacy may send a large supply of morphine to a terminal patient, and the lion's share goes down the toilet. Unnecessary when shipments are done daily and we have emergency stock in the facility. Control the amount of RX which can be refilled.

► Please do not consider ICF/MR & RHCs an optional service. Please remove ICF/MR and RHC's from the optional services list.

(MAA note: ICF/MR and RHCs are classified as "optional services" by the federal Medicaid program, which means states may choose to provide them or not. Washington State has chosen to provide them, and the waiver proposal would not affect these services.)

► A few comments: I may have more as I think about this more.

1. There should be a residency requirement of say at least three months before people can get aid (except for children, pregnant women and true severe emergencies like a car crash, heart attack) like Oregon's. We shouldn't have to pay for everyone who drops by.

2. Since payments to physicians are so low, most, if not all, are not taking any new Medicaid patients in my community. This leaves patients nowhere to go except the ER.

3. I don't think there should be a freeze. People lose jobs because of the economy in general and if they lose their job late in the year, they'd be out medical as well.

4. I would recommend co-pay for all visits for adults but never a co-pay for children. They cannot themselves pay a co-pay and the adults who may use their money for drink or drugs would never take them to see their doctor with a co-pay.

5. Co-pay for proprietary drugs that have a generic is appropriate.

► 1) Some fear children won't receive necessary health care because their parent or guardian won't be able (or won't be willing) to pay money for health care. If so, then waive co-payments for Medicaid patients under 18 years old.

2) Otherwise co-payments are prudent and not burdensome. We, the working taxpayers, should not pay every penny of health care (two billion dollars annually in Washington) for those on welfare.

3) A co-payment should be required at the point of health care service delivery on that same date. Otherwise health care providers will be stuck with even lower reimbursements and no way to collect from the Medicaid clients after health care has been dispensed. (Medicaid reimbursements are already below the actual cost of delivering the care [i.e., charity]).

4) The \$10 co-pay for non-emergent care through hospital emergency departments is overly generous to Medicaid clients. Truly non-emergent care should be diverted from our already-overcrowded ER's. For many of us working taxpayers with job associated health care benefits, the insurers will not reimburse any of the cost of non-emergent care obtained from ER's. This is a prudent rule and one that Medicaid recipients should also follow.

► This proposal is a draconian attack by the state of Washington on its most defenseless adults and children. The people who generally qualify for Medicaid coverage are people who live on the bottom rung of this society. They qualify for Medicaid only because they haven't enough hours in the workplace to qualify for Medicare if they are disabled or they have been disabled at birth. Their income is likely to come from SSI, which for an adult is probably around \$500 per month. To ask these people to pay when they have no disposable income is barbaric.

► I am very concerned about any payments I might need to pay because I live on only \$6,000 a year. I can hardly live on what I receive now. I must see three different Doctors and have prescriptions of at least five a month. I would not be able to pay all that money for the services. Must I go without food or medications?

It is so hard for people like me that have long-term disabilities to hear changes like this that could affect me. It makes one feel so helpless. We are people who are unable to work and have no other source of income. It is not a choice for some of us. We should be able to enjoy our lives to the best of our abilities and not have to worry about our type of care.

Perhaps cuts could be made in other areas. I am sure there are many programs that could be cut to some degree.

Please do not give Medicaid people any more pain than they already have.

► I am writing in response to the proposal featured in The Olympian last week concerning Medicaid reform. I would like to say that I am in favor of the reforms to give Medicaid recipients more responsibility for their health care.

The cost of Medicaid will never decrease if the recipients have no incentive to seek the most reasonable necessary care. If there were a co-pay for medications based on cost, the patient would be much more likely to opt for a generic or more reasonably priced medicine. The same goes with the frequency of hospital emergency room visits.

As a retired RN, I have had experience with patients whom I advised to go to the doctor's office for a \$50.00 visit rather than a \$300-\$500 ER visit. The patient often chose the ER because "it won't cost me anything."

Those of us who are fortunate enough to pay for medical insurance have our choices controlled by our insurance companies, and have to pay more for emergency room visits and brand-name drugs. Many of us also have to pay a co-pay besides our insurance premiums.

I am in favor of the Medicaid program. It is necessary to provide health care to those who can't afford insurance. However, we do these people a disservice when we take away all their responsibility. They need to be active participants in controlling health care costs. Otherwise, there may not be enough money for all people who need help to get it.

► I'm writing regarding the co-pay for Emergency Department (ED) visits. I'm an emergency physician and have practiced in Spokane for 15 years. I deal with many Medicaid patients daily. I feel it's very appropriate to have some personal responsibility tied to health-care decisions, i.e., a co-pay. However, I see some problems with this proposal, as I understand it.

1) I hope the plan isn't to make the hospitals collect the co-pay. We can't legally demand payment from any one at the time of service. Therefore, it won't get collected by the hospitals. Thus, I'm concerned that this is somehow a scheme to decrease our already miserable rates from DSHS by \$10?

2) How do you determine what is an emergency? The federal government has already tackled this issue. It's called the prudent layperson law. How does DSHS propose to define an "appropriate" visit?

3) This is a very sticky subject. One person's emergency is another person's routine issue. DSHS shouldn't go there. If a co-pay is necessary, just charge for all visits.

4) How much money does DSHS think it is going to save? Most managed care organizations have given up trying to decrease ED visits -- I think, for two reasons. One, it doesn't work. Two, it really doesn't save much money. The marginal cost of providing care in the ED really isn't that much more than providing care in an office.

5) Is DSHS asking the right question? Which is why do their clients choose to use the ED? I think one author put it best: "Why doesn't everyone use the ED? It's convenient, there is good access to specialists and technology, and for the most part the doctors and nurses treat the patients with respect and kindness.

6) My last concern is for medicine in the state of Washington in general. If the state doesn't address the declining rate of reimbursement for its physicians relative to other states there won't be any doctors to go see, because they will all have left. It's already happening. Thanks for the chance to give my opinion.

PS. The proper term is Emergency Department, not Emergency Room.

► I support the proposed Reform Waiver changes. As an advocate of health care, I really do think that contributing to one's health, even in the form a small co-pay or premium makes sense for everyone involved. It would give the patients a sense of ownership in their health care, and the stigma of "handouts" or "free" would be lessened. It would also alleviate the huge financial burden that the state is faced with providing adequate healthcare in this area.

► Thanks again to you and your staff for coming to Bellingham to hear community comments about the proposed Medicaid waiver. I've put into writing a summary of my comments and additional thoughts since the meeting.

I have followed the development of this proposed waiver since last year. I had concerns then, and I continue to have concerns about the proposal. As an Area Agency on Aging, advocating on behalf of older people and people with disabilities, we have concerns about how this waiver will negatively affect the more vulnerable among the consumers we serve.

As you know, I wanted very much to say something positive about the proposed waiver and the State's efforts to control costs during this immensely challenging budget situation. I do honestly compliment you on the town meetings; beyond that, I find that I can't really make positive comments on any element of the waiver.

I do, on the other hand, have significant concerns about the proposed Medicaid waiver.

First, the success of this particular waiver seems to be evaluated solely by fiscal measures. Waivers give an opportunity to create programs that make more sense as well as to potentially save money. The COPES long-term care waiver is an example of that two-pronged approach. My concern about this waiver is that fiscal management doesn't seem to be realistically coupled with the critically important issue of protecting Washington's most vulnerable residents in a reasonable way.

Second, I'm sorry to say that the informational materials I've seen that emanate from the State have a somewhat oversimplified "marketing" quality to them. A realistic and forthright description of the waiver's elements, positives, and negatives would more likely convince stakeholders that thoughtful and balanced analysis and problem-solving were involved in the development of this particular waiver approach.

Third, I have concerns about the few concrete strategies that are outlined in the proposals. The concept that any co-pay or premium contribution would be "reasonable" for families with such severely strained incomes doesn't ring true. And I have concerns about whether there is any firm evidence to suggest that such contributions will do anything except entirely exclude people from receiving services, or balance the budget on the backs of those community providers who will ultimately be unable to collect the payments.

Fourth, I'm concerned about the strategy that allows for significant program cuts that cause harm to people without the public policy debate that should shape such significant decisions. Normally significant changes are made after extensive legislative policy debate and analysis; the structure for program freezes in this waiver allows for such debate only after the fact.

In summary, I believe this waiver needs to go back to the drawing board for more research, analysis, and honest discussion about the pros and cons of various approaches. No one denies that the State of Washington is in a budget crisis of a proportion not seen in the last two decades. Such a crisis deserves our best efforts to create reasonable strategies, including looking at ways to raise revenue to meet the health care needs of our residents. It is NOT time to step away from our longstanding commitment to health and long term care for people in need.

Thank you again for the opportunity to comment.

► I am president of the NAMI Tri-Cities affiliate and want to keep our members up to date. Because many mentally ill adults are unemployed, NAMI - Tri-Cities members have an important stake in the Medicaid program and any changes proposed for it.

► I am very concerned about the proposed plan to impose premiums and co-payments on some Medicaid clients. If you are so poor you don't have health insurance, you can't afford co-pays and premiums! We could have a statewide epidemic if poor people don't have insurance.

My daughter is a Medicaid recipient. We adopted her as a special-need child. But we are a middle-class family with primary insurance. If you want to charge anyone co-pays and premiums, please only charge people like us, who can afford it. I am not sure how many people like us are in the system, but it's a place to start.

► We cannot afford 5 percent of our income, for starters!

► I am writing to give the state my opinions about the proposed Medicaid waiver. I would come to one of the town hall meetings but, my illnesses prevent me from going so, I am sending you this e-mail.

I am greatly concerned about the proposed changes to Medicaid. I have chronic disorders that I deal with daily. Some of these are Common Variable Immunodysfunction, Primary Thrombocytopenia, asthma and a lung disorder. These disorders make me unable to work even part-time.

Ever since I learned about the first waiver that was proposed I have been opposed to it. A state official has been quoted in the local media as saying that Medicaid recipients are not aware of how much their health care costs. In my case, this statement is totally false. I am well aware that my medical care is expensive, but I also know that my life is being saved by the same treatments. My immune disorder can only be treated by the use of IV Gamma Globulin, an expensive blood byproduct that has to be administered at least once a month in an outpatient clinic. This is also the treatment that is used if my blood disorder causes a low platelet count.

My main worry about the proposed waiver is the idea of charging co-pays for prescriptions if they are not on an approved list. How am I to know if all my medications including the immune globulin are on this list? Charging a co-pay to someone who is below the poverty line does not seem sensible to me. Co-pays for ER visits are also a concern to me. The only time I use ER's is when I have what I feel is life threatening problems such as infections with fevers, breathing problems and serious bleeding. I have been living with most of my disorders for over twenty years, believe me I can tell when I need an Emergency Room visit. I do not use the ER instead of my primary care doctor. I would much rather see my doctor in Bellevue instead of going to the hospital in Seattle. I do not consider ER visits as enjoyable. Has your office even looked into who is going to be delegated the duty of saying whether an ER visit is emergent or not? Are you going to add this to already overworked ER staffs? I see great problems with a co-pay being charged for any health care, I can envision people like myself going without medications because they do not have the money for the - delaying life-saving treatment at an ER for the same reason. How many deaths is it going to take before this error in judgment is reversed?

I also am a mental health consumer and attend a community mental health centers day treatment program whenever I feel well enough. I am concerned about proposed cutbacks in mental health spending. With the cutback already in place I can see that patients are falling through the cracks because they are not on Medicaid. Now there is talk about cutting back more, I am concerned about this. Without treatment the mentally ill could end up hospitalized, incarcerated or homeless. These could cost the state more money. Why not increase spending to outpatient clinics, which are more cost effective?

Thank you for reading my concerns, I am hopeful that the state will decide against the proposed waiver.

► Please REMOVE ICF/MR services from the proposed Medicaid waiver optional services list, and leave it alone. Don't threaten our most vulnerable citizens, our profoundly, severely retarded, medically fragile and multiply-handicapped loved ones to increased hardships by stripping away and blocking needed services as needs arise, including those still properly unserved in the community, and those who require this intensive care available only in our state residential habilitation centers.

(MAA note: ICF/MRs are classified as "optional services" by the federal Medicaid program, which means states may choose to provide them or not. Washington State has chosen to provide them, and the waiver proposal would not affect these services.)

► I have strong objections to the plans to request another waiver for Medicaid recipients. My concerns are specific to the fact that folks who may not have a co-pay might put off treatment until a medical condition then becomes extremely expensive to treat. I also am worried that the waiver can allow the demise of some programs or a reduction in services.

The waiver is not the solution.

► *"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."*

-- Margaret Mead, 1901-1979

► I wanted to commend your efforts to reaching out to the Yakima community regarding the proposed changes to Medicaid.

After listening to the proposal and open forum that occurred afterwards, I would like to say that I am not opposed to implementing a co-pay and premium payment to those that are on the fringes of the Medicaid program. I believe that most of these people are at the cusp of meeting eligibility requirements for either Medicaid services or getting onto the Basic Health Plan, and as such, would be able to pay for some of their health benefits. However, we must ensure that those that are designated as truly needed are not affected. Stricter guidelines and more frequent eligibility auditing procedures must be implemented, as well as educating the consumer on how the system works.

There was a comment made by Doug Porter that those on the Basic Health Plan pay premiums that range anywhere from the 10-60 range per month - I am highly doubtful of this. I would like to receive information regarding the percentage enrolled and premium payments. Is there anyway I can review this information?

(MAA note: The premium breakdowns are listed on the Health Care Authority Web site, at <http://www.wa.gov/hca/basichealth/doc/hmwbhcc.pdf>)

► I would very much like to participate in the future of Washington. Even though we are in a small and rural area we deserve representation. The changes that are coming about greatly affect our jobs and our community. However, seeing that the nearest meeting for us would require 4-6 hours of travel time, attending them would be a hardship for me.

► I'm writing on behalf of myself and staff here at Community Medical Center, Brewster, WA. We are all trying to stay up to date with all the healthcare changes for our state, and strongly feel that we too, deserve representation regarding issues that affect us, our community and our healthcare. We find that it just isn't workable for us to travel 6 hours for a meeting on the other side of the state. Nor do we have the finances, time or staff to lose for it.

We really want to be strong participants in our states healthcare, but with limiting meetings in our 'rural' area make that hard to do.

► Is there anyway some negotiating on your behalf be done to include (the Wenatchee) area and all of us in your representation of your business as well as issues, meetings, or even some tele-conference seminars?

► I am requesting that you have a community meeting in the city of Wenatchee. My understanding is that there will not be a meeting held closer than two to three hours from here which would be a six hour round trip. I want to be able to participate in the meeting, but feel that our area is not being included. DSHS decisions will greatly affect our economy and health care and I feel my ability to provide input is limited by not having a meeting closer to my area.

► I work in a small family practice clinic in central WA. Here are some comments/ideas I have to save Medicaid money.

- Make OB patients who have current private insurance coverage continue their coverage throughout the pregnancy (unless they or spouse terminates employment through the company they are insured with). I see so many times as soon as a woman gets First Steps they terminate their regular insurance for the remainder of their pregnancy and use Medicaid as their primary. After the birth they get back on the regular insurance.
- Set a penalty for not reporting that you have auto insurance when seeking care after an auto accident. Almost all the patients we have who are on Medicaid and who have an auto accident claim that they do not have auto insurance....Isn't it a law that they must?! But we have no way of checking if they do -- only if an auto company requests information in order to pay a claim after the patient has already told us they do not have other insurance.
- Better verification of income!!! We have lots of Medicaid and Basic Health patients who live in HUGE EXPENSIVE houses and have 2-3 new cars in the driveway, but apparently are low income??

► Many questions:

1) Why are non-English speaking children who have Social Security numbers, born in U.S., receiving letters of dismissal?

2) How can DSHS tell if an undocumented family has been in the U.S. for less than 5 years and how does the department make a decision about who to include and who to exclude?

3) Are individuals of all ethnicities receiving letters: Hispanic, Ethiopian, Albanian, Korean?

4) Will all people who apply for Basic Health receive it? If so, when will coverage begin? What will premiums be -- a family of 5 living at 150% of federal poverty level?)

► Our community is impacted "greatly" by the changes that DSHS is making and has already made. It is imperative that we, as a community, are allowed to voice our opinions and concerns. The changes DSHS is making will affect our community growth, our jobs and our well-being. There is no way, in trying to maintain the job we have, that we are able to travel for 6 hours in a day to attend a meeting that is not in our area. I feel that we all deserve a voice in what is happening. After all, there isn't one person that these changes don't touch in some way. PLEASE include us in the future meetings in an area that we aren't left out.

► I have just reviewed the survey form, and find it misses the mark in a couple of ways:

- 1) There's no option given for those who feel ER co-pays or premiums might be inappropriate.
- 2) Wording on the enrollment freeze is confusing - does "include" mean in the freeze or in the services?
- 3) All questions make assumptions that the changes are possible.

► As a Medicaid recipient, as a college student moving into a social service career, as a person with a disability, as a parent of a child with a disability on SSI, I would like to respond to the proposed changes. I would like to do so section by section, so I have posted each portion before my response to that section to organize my response.

PROPOSED: *Under Medicaid Reform and subject to legislative approval, clients would pay a small premium to help pay for their health care coverage. People below the Federal Poverty Level would not be charged premiums but could face reasonable co-pays. People above that level would also contribute small monthly premiums, although the waiver specifies that out-of-pocket expenses would not be more than 5 percent, on average, of a family's income.*

RESPONSE: I am all for a "buy-in" option to Medicaid with staggered premiums and co-pay levels. I do feel it is vital to keep medical for children and adults who meet income requirements for TANF, FS, Head Start, WIC and other programs where eligibility depends on income falling below. Established federal and state poverty standards should remain co-pay- and premium-free. I can not tell you the times I have taken a sick child to the doctor where the most often recommended treatment is simply children's acetaminophen and I have not had \$5 in my pocket to purchase this for my child nor had resources such as friends or family who could loan me the money. This is everyday for those of us who must make choices like this: Will I spend the \$3 in change I have to buy OTC medication or a simple meal with macaroni and cheese? It is not about not saving or poor budgeting either. Simply put, high housing cost, increasing utility bills, failure of federal and state standards to accommodate the cost of living inflation, most of us make horrible choices each day about what bills we will not pay. These are decisions about essential needs, not luxury items such as cable. I for one have never had cable TV and cannot recall the last time I ever went to see a movie or went out. Children will be at the most risk from this proposal and will be less likely to receive antibiotics, allergy medications, anti-depressants, ADHD CNS medications, neuro-leptic seizure medication and much more. Parents in this category are often unable to meet even a \$5 cost for a co-pay. Parents are further hindered in that social service agencies who have helped in the past with emergent medical cost for subscriptions are already overwhelmed in attempting to meet needs caused by the recessed economy, the working poor, and welfare reform. I stand opposed to this section. However, I would consider a rewrite that allows a buy-in option to those who exceed the poverty standard required for most social service programs.

PROPOSED: *The amended waiver would create two different co-payments, both aimed at avoiding costs, not at raising revenue. A (about \$5) co-payment would be charged to clients who insist on higher-priced brand-name medications even though lower-cost therapeutic equivalents or generic drugs were available (clients would not have to pay co-payments if medically necessary.) A (about \$10) co-payment would be charged to clients who obtain non-emergency care at hospital Emergency Rooms. In either case, clients could avoid the co-pays by either accepting the less expensive prescriptions or by visiting providers' offices, not the ER.*

RESPONSE: It is already current Medicaid policy to pay for and provide the generic drug rather than a brand name when it is available. This is essentially redundant. When a name brand drug is necessary it is extremely difficult to get approval for that drug. Case example: I am

diagnosed with Ankylosing Spondylitis and (my doctor) recommended and prescribed the drug Celebrex for me. This drug is fairly new and a generic is not available or was not available at the time it was prescribed for me. Four times my doctor submitted the forms to get approval of this drug as medically necessary. Each time it was denied and instead Medical Assistance approved of treating me with methotrexate a chemotherapy drug with toxic and some times dangerous side effects. I got pregnant on this drug and went through a life-threatening pregnancy. This drug also depleted my bone marrow and caused a chronic leukemia and anemia in me. I am still trying to recover. I receive no treatment for and have been booted from TANF because I have been unable to work. Prescribing Celebrex might have prevented further disability to my person. Any time a generic has been available I have never been offered a choice of that drug. Not only that but a child of mine treated for ADHD was unable to get his prescribed medication because Medical Assistance policy would not cover the extended release form of the drug and in that dose because of his age. Adderal can be prescribed and covered as Adderal XR only to children ages 6-12, and Adderal (generic amphetamine salts) ages 12-21 only. Folks, this is discriminatory, and if it happens again I will be filing an ADA suit for discrimination against DSHS Medical Assistance. If you would like to offer non-generic coverage with a co-pay I would be happy to take that. Currently, though, if a generic is available then that is all a person can get. AS for co-pay for non-emergent visits to an ER, this is a really bad idea. I used to work in nursing and often determining what should or not be seen in an ER is not all that simple. Here the state is attempting to be the physician. This will also open the state up to lawsuits. Some situations cannot be determined the severity or non severity until evaluated by a physician. The majority of medical recipients are enrolled in managed health care plans and most of those require calling a referral line before authorization to an ER unless obviously life-threatening. Bottom line, you need to toss this one out the window. If you seriously want to cut costs here, then rewrite this part and consider co-pay or penalty pay for multiple-abuse of an ER with a verified chronic illness by a physician with a right to appeal if a person can verify within three months that they have been diagnosed with a chronic health impairment since the last ER visit. Sometimes multiple ER visits might finally help a person become diagnosed.

PROPOSED: *Medicaid Reform would allow the state to adjust benefits for adults within optional programs, using the state's Basic Health program as a model and including outpatient therapies. Basic Health does not include some coverages, such as dental or vision, but does cover the most important categories such as major medical or hospitalization.*

RESPONSE: This will deny services and coverage to more vulnerable populations as in disabled adults. Dental health is vital and important in maintaining long term health and in lowering health cost in the long run. Elderly who have had inadequate dental care suffer a greater range of health issues than those who have had care. Their health is more likely to deteriorate faster, too. Healthy teeth promote better nutrition and nutrition is vital to long-term health. The populations most affected by this section will be the disabled adults and elderly. Vision is perhaps an area that can be adjusted allowing an opt in or out. There are now eye providers that cut the cost well below what Medicaid can do. For instance, I pay \$20 for a pair of contact lenses and have purchased a 5-year eye-plan for \$99 and under it receive unlimited free eye exams. Eyeglasses can now be purchased for as low as \$39. Medicaid just cannot compete with that and HMO's are ripping you off. Allow an option to opt out if corrective vision services are not needed, opt to use a alternative service that saves the state money, or use vision care with their HMO. You do need to save ophthalmologic services for eye disorders when referred by a primary as in care for cataracts or glaucoma. As for restructuring and packaging care for adults services are already extremely limited. Medical Assistance needs to ADD better access to mental health care such as

referral to a psychologist or psychiatrist by a primary when the primary has verified that local mental health agencies are unable to meet the specifics of the patient, i.e. neuro-psych evaluations and the agency is not staffed by qualified neuro-psych and is staffed by social worker counselors with MA. Or it is determined the wait for mental health services at three or more agencies will result in the patient waiting more than 30 days for services.

PROPOSED: *Medicaid Reform would allow the state to freeze enrollment in optional Medicaid programs during circumstances in which enrollment and expenditures are rising at a rate that will exceed the funds appropriated for medical assistance by the Legislature. The important reason for such a freeze is that it would protect current enrollees, rather than force the state to throw everyone out of a given program. These doomsday budget forecasts are real. The state is currently weathering a \$1 billion shortfall in this equation that occurred during the current biennium. Forecasters say the state should expect the same kind of shortfall in revenue during the next biennium, too.*

RESPONSE: Keep this restricted to optional programs only. Yeah, as a Medicaid recipient even I understand this issue. I do feel it is the state's obligation and the obligation of DSHS to enter into public information campaigns to educate the public about who receives medical assistance and why, and to dispel myths. As a former nurse who worked in geriatrics a large portion of patients were on Medicaid with nursing home bills eating huge amounts of the state I worked in Medicaid budget. You – Medical Assistance and DSHS need to publicly campaign to show that people who receive medical are disabled adults, disabled children, elderly, and foster children. You need to show what the numbers are by category so people see that Medicaid is not just welfare moms. Despite budget shortfalls and to keep from being shortchanged and cut further, you need to campaign during budget hearings and you need the public support to get legislators to vote more budget friendly towards Medical Assistance. Yes, everyone has to pinch somewhere but unless we all scream and scream loudly and protest then no one will care what gets cut for Medicaid. You need to engage in this public information campaign also regarding the varied tax reduction proposals because every dollar cut in taxes cuts services. If it cuts the highway budget, that's less dollars there is to spare to allocate to DSHS Medical Assistance. When tax initiatives come up people need to keep in mind its not just about if a pothole gets fixed. It may be about if grandma will have a bed in a nursing home and will she get her diabetic medications?! If laws prevent you as an agency from this public information campaign, then partner with someone like the Children's Alliance or other advocacy agencies. But give them the tools with the numbers. They need the data about what type of people receive Medicaid and what happens when budgets are not met.

PROPOSED: *Medicaid Reform also would allow Washington State to use its unspent SCHIP dollars that we now have to return to Washington, D.C. Instead of giving the money back, we want to use it to help provide medical coverage through the Basic Health program to uninsured parents of Medicaid children and childless adults.*

RESPONSE: Given all the above, I have to ask: WHY is this money not being spent? Do like you say in this section. Add mental health coverage or expand to more children. Expand children's mental health coverage to visits with private other mental health providers like psychologist, psychiatrist via primary care referral and the mental health provider willingness to meet a Medicaid standard reimbursement scale. I have met psychologists who would be willing to treat patients on medical assistance even with the lowered payment reimbursement but say they are prevented from doing so by DSHS rules that ay children must have their needs met by Spokane Mental Health. I have tried for 5 years to get services for my children through Spokane Mental

Health. I'm still waiting. Expand vision, dental, immunization clinics to elementary schools. Do something, but don't give up this money!

Thank you for your time and allowing me to respond in detail to each part.